Professionally Responsible Referral for Assisted Reproduction

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Infertility is one of the most common clinical challenges faced by the practicing obstetrician-gynecologist. Referral to a specialist in reproductive medicine is often of clinical value. This paper provides an ethical framework for this referral process, based on the professional responsibility model of obstetric and gynecologic ethics. The professional responsibility model is based on the ethical concept of medicine as a profession, which requires obstetrician-gynecologists to make 3 commitments: to scientific and clinical competence, to making the health-related interests of patients primary and individual self-interest systematically secondary, and to sustaining medicine as a public trust for the benefit of current and future patients. We identify the implications of each commitment for professionally responsible referral of patients to specialists in reproductive medicine. Professionally responsible referral of patients for assisted reproduction encompasses distinctive ethical obligations, the fulfillment of which will prepare patients for cognitively and affectively demanding shared decision-making about this potentially life-altering form of gynecologic care. (J Reprod Med 2019;64:87–89)

Keywords: assisted reproductive techniques; decision making; female; gynecologists; human rights; humans; infertility; liability, legal; models, theoretical; obstetricians; obstetrics/ethics; patient rights/ethics; personal autonomy; pregnancy; professional responsibility model of obstetric and gynecologic ethics; professionalism/ethics; referral.

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It is estimated that about 15% of couples do not achieve pregnancy after at least 12 consecutive months of unprotected intercourse. About 50% of couples will spontaneously conceive during the second year, another 14% will conceive in the third year of unprotected intercourse, while <5% will remain childless.[1] About 50% of all cases of infertility are due to female factors alone, 20–30% are caused by male factors alone, and the remaining 20–30% are due to a combination of male and female factors.[1] Reproductive endocrinologists have a range of assisted reproductive techniques to assist infertile couples, from ovulation induction, intrauterine insemination, and in vitro fertilization,

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Financial Disclosure: The authors have no connection to any companies or products mentioned in this article.

0024-7758/19/6403-04–0087/$18.00/0

to third party reproduction (oocyte and sperm donation, gestational surrogacy). A PubMed search ("assisted reproduction," "referral," and "ethics") found no citations providing ethical guidance for the practicing obstetrician-gynecologist referring a patient for assisted reproduction. This paper provides an ethical framework for this referral process, based on the professional responsibility model of obstetric and gynecologic ethics.

The Professional Responsibility Model of Obstetric and Gynecologic Ethics

The professional responsibility model of medical ethics is based on the ethical concept of medicine as a profession,[2,3] which was articulated by 2 physician-ethicists, John Gregory (1724–1773) from Scotland and Thomas Percival (1740–1804) from England.[4] They did so in response to a crisis of intellectual and moral trust among the sick who sought help from physicians and surgeons. In eighteenth-century Britain there was no uniform curriculum in medical schools or licensure. The market for fee-for-service physicians was small and intensely competitive, with physicians and surgeons pitted against female midwives, apothecaries, and "irregulars." There were almost as many theories of health and disease, and regimens based on them, as there were practitioners. This resulted in a loss of intellectual trust: the fear that practitioners did not know what they were doing.[4,5] The sick also worried that practitioners proposed clinical management on the basis of their own financial self-interest and not the well-being of the patient. This resulted in a loss of moral trust: the fear that physicians and surgeons just wanted to line their pockets with the patient's money.[4,5]

Gregory and Percival insisted that clinical practice be based on science. They appealed to the philosophy of medicine of Francis Bacon (1561–1626), who called for medicine to be based on "experience." Bacon did not use "experience" to mean a clinician's personal experience, because it was subject to bias. Instead, Bacon used "experience" to mean the carefully observed, analyzed, and reported results of natural and controlled experiments. This was a nascent form of evidence-based medicine. Practicing medicine on the basis of Baconian experience would reduce bias to a minimum and thus make physicians and surgeons intellectually trustworthy.[4]

Gregory and Percival argued that clinical practice should be based on the concept of "sympathy," as described by David Hume (1711–1776): the natural capacity to enter emotionally into the lived experience of others and thus become motivated to help them when they are in distress. Sympathy-based clinical practice makes the patient's health and life the primary concern of physicians and thereby makes self-interest a secondary consideration. This becomes an antidote to moral distrust of self-interested individual physicians.[4]

Gregory and Percival rejected the guild mentality of physicians and surgeons, i.e., acting in ways that protect the self-interests of the group. Gregory called this the "corporation spirit," referencing the royally chartered guilds. Sympathy requires that group self-interest be kept secondary. To achieve this goal, physicians should regard medicine as a "public trust" (the phrase is Percival's). This becomes an antidote to moral distrust of physicians as a self-interested group.[4]

The ethical concept of medicine as a profession can be summarized in 3 commitments: to scientific and clinical competence, to making the health-related interests of patients primary and individual self-interest systematically secondary, and to sustaining medicine as a public trust for the benefit of current and future patients.[6] Each of these commitments has implications for professionally responsible referral of patients to specialists in reproductive medicine.

Clinical Implications of the Professional Responsibility Model of Obstetric and Gynecologic Ethics

Implications of the Competence Component

Obstetrician-gynecologists have the ethical obligation to ensure that each patient receives evidence-based clinical management of her condition of infertility. Obstetrician-gynecologists not specializing in assisted reproduction are competent to complete a work-up and evaluation of a patient who is trying but failing to initiate a pregnancy. For most patients, this will result in a treatment plan that the obstetrician-gynecologist, with the patient's consent, will implement with the patient. If this clinical approach fails to be effective, the obstetrician-gynecologist should consider referral to a reproductive medicine specialist.

The professional responsibility model creates distinctive ethical obligations of the referring obstetrician-gynecologist. Referral should be made to a specialist who is reliably known (1) to pro-

vide evidence-based care, (2) to comprehensively collect, analyze, and report pregnancy and take-home baby rates to patients, (3) to provide a thorough informed consent process, (4) to take the time necessary to address patients' questions, and (5) to be transparent about financial costs to the patient. The referring obstetrician-gynecologist should seek assurance from the specialist that he or she will be available for consultation with the referring obstetrician-gynecologist for the clinical management of medical complications of assisted reproduction that might occur.

Implications of Primacy-of-Patient's-Interests Component

The professional responsibility model creates distinctive ethical obligations to the patient who accepts referral. The referring obstetrician-gynecologist should (1) provide an overview of what the patient should expect and prepare the patient with questions she should be willing to ask, (2) assist the patient to distinguish 2 meanings of "success"—between pregnancy rates and take-home baby rates, (3) assist the patient to be aware of potential medical contraindications that should be addressed by the specialist, (4) assist the patient to be aware that there are biopsychosocial risks from assisted reproduction, and (5) encourage the patient to ask about financial costs to the patient.

The referring obstetrician-gynecologist should explain the essential role for shared decision-making, which applies when there are competing alternatives,[7] including accepting and living with infertility. Shared decision-making is designed to protect patients who may be vulnerable to making an incompletely informed or hurried decision. To support shared decision-making, the referring obstetrician-gynecologist should offer to schedule a visit to go over what the specialist has said and elicit and address the patient's questions to the patient's satisfaction, reporting this conversation to the specialist. When there are potential medical contraindications to pregnancy, there should be referral to a maternal-fetal medicine specialist to ensure that the patient has carefully considered these contraindications. For patients who express hesitation or appear uncertain, the referring obstetrician-gynecologist should "give permission" not to seek further assisted reproductive medical services and support patients who decide to end use of assisted reproduction. This last step, unfortunately, is sometimes neglected.

Implications of the Public-Trust Component

Professional self-regulation is an essential aspect of the public-trust component. If a referring obstetrician-gynecologist has evidence of inappropriate clinical management by the specialist, the referring obstetrician-gynecologist should report to the appropriate professional associations, licensing, and regulatory authorities.

Conclusion

Professionally responsible referral of patients for assisted reproduction encompasses distinctive ethical obligations, the fulfillment of which will prepare patients for cognitively and affectively demanding shared decision-making about this potentially life-altering form of gynecologic care.

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